Dermatology & Allergy Specialists of Olympia, PLLC

Mohs Dept: 304 West Bay Dr NW, Suite 204, Olympia, WA 98502
Voice: (360) 413-8760 Fax: (360) 413-8839

Jacob Bauer, M.D.

APPOINTMENT DATE:_____ TIME:_____ FLOOR: 2 MOHS SURGERY

Thank you for choosing our Dermatology office! We look forward to making your visit as comfortable and productive as possible. The following steps will help us provide the best use of your time with the provider:

- ***Minor Patients: All minors must be accompanied by a parent/legal guardian at each visit. If not accompanied by parent/legal guardian the appointment may be rescheduled.***
- **Please arrive 15 minutes early so we can register/update your information.**
- **Please provide ALL insurance cards, Picture ID, POA and/or current ProviderOne card if applicable:**
  - ***Current insurance card/s are required by your insurance company to be presented at every visit to our office. Your appointment will be rescheduled to the next available appointment if you do not present all insurance cards at registration.***
  - *Your insurance company obligates us to maintain a copy of your insurance card in your medical record for the purpose of billing your visit.*
- Please refrain from wearing perfume or colognes to our office. Many of our patients have severe allergies, and as a courtesy to them our office is a "scent free" zone.
- Bring your referral, if required. Your insurance company can tell you if you need a referral; we are unable to contact them for you. If your insurance company requires a referral and one is not provided to us, your appointment will be rescheduled.
- Please be prepared to pay your co-pay at the time of check-in if one is required. We charge a $5.00 fee to bill you later for co-pays.
- Please bring in the containers of any medications or over-the-counter products that you are using to treat the current problem.
- Please read entire packet and completely fill out any forms sent to you before arrival.
- *Individuals seeking treatment are not considered to have been accepted into the practice and formed a provider-patient relationship until they have completed a face-to-face visit with a provider who has completed an evaluation and assessment.*

We recommend you allow plenty of time for your first appointment. This initial visit takes time to register, and we do not want to shorten your time with the provider or have to reschedule your appointment if you are late. Due to the shortage of dermatology providers, your appointment may have been scheduled some time ago, and it may not work with your current schedule. Please call us as soon as you are aware that you need to reschedule. With 24 hours notice, we are happy to reschedule; however the new time might be several weeks later. ***If you fail to keep your appointment without notifying us in advance, you will not be rescheduled again.***

For your convenience, our appointment line is available to take a message 24 hours a day. Please call (360) 292-7700 if you wish to leave a message. You may call us during office hours of 8 a.m. to 5 p.m. Monday through Thursday, or 8 a.m. to 4 p.m. Friday, to reach a receptionist.

DIRECTIONS: Please see reverse side.

Directions to Dermatology & Allergy Specialists of Olympia

TRAVELING SOUTH on I-5, EXIT 105B:

Head west off Exit 105B, down ramp and travel 0.3 mi. Merge onto Plum St SE. Follow Plum St. to State Avenue, approximately 0.6 mi. Turn left onto State Ave NE and go 0.6 mi. Stay to the right and merge onto 4th Ave W and cross the bridge. At the first traffic circle, stay to the right and follow Olympic Way to the second traffic circle. Stay to the right and take the 1st exit on the right: West Bay Drive NW. The office will be one block down on the right.

TRAVELING NORTH on I-5, EXIT 103:

Head down the ramp to Deschutes Way SE and remain on this road as it becomes Deschutes Parkway SW. Continue on Deschutes Pkwy SW along the west side of Capital Lake for 1.8mi. Deschutes Pkwy turns into 5th Ave at the junction with the bridge. Travel for 0.1mi. Turn left on Simmons Street NW. Turn left onto 4th Ave W and cross the bridge. Merge into right lane and at the first traffic circle, stay to the right and follow Olympic Way to the second traffic circle. In the right lane take the 1st exit on the right: West Bay Drive NW. The office will be one block down on the right.

TRAVELING EAST on Highway 101:

Take the Black Lake Blvd exit toward W Olympia. At bottom of ramp turn left onto Black Lake Blvd SW, Travel 1.2mi. Turn right onto Harrison Ave NW and go approximately 0.6mi. As you head downhill, stay in left lane as you enter the traffic circle. Proceed around to the left, merge to the right and take the 2nd exit (right) onto W Bay Drive NW. The office will be one block down on the right.

Dermatology & Allergy Specialists Of Olympia

304 West Bay Dr. NW, Olympia, WA 98502; General Dermatology, Ste 301; Mohs, Ste 204

Date: _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial _____

Marital Status: Single / Married / Divorced / Widowed Sex: _____ Date of Birth: _____

Mailing Address: _____City: _____State: _____Zip: _____

Physical Address: _____City: _____State: _____Zip: _____

Primary Phone#: _____ Secondary Phone#: _____ Email: _____

Emergency Contact: _____Relation: _____Phone #: _____

Employer: _____Work Phone #: _____SS#: _____

Spouse/Guarantor/Self (Please Circle)

Last Name: _____ First Name: _____ Middle Initial _____

Sex: _____ Date of Birth: _____

Mailing Address: _____City: _____State: _____Zip: _____

Contact Phone #: _____ Email: _____

Employer: _____Work Phone#: _____SS#: _____

Insurance Information

(PLEASE PRESENT INSURANCE CARDS AND NECESSARY REFERRALS TO THE RECEPTIONIST SO COPIES MAY BE MADE)

Primary Insurance: _____ Insurance Phone #: _____

Ins Address: _____Policy#: _____Group#: _____

Subscriber: _____Subscriber's Birthdate: _____

Relation to Patient: Same / Spouse / Child / Other (Please Circle) Subscriber's Employer: _____

Secondary Insurance: _____ Insurance Phone #: _____

Ins Address: _____Policy#: _____Group#: _____

Subscriber: _____Subscriber's Birthdate: _____

Relation to Patient: Same / Spouse / Child / Other (Please Circle) Subscriber's Employer: _____

Dermatology and Allergy Specialists of Olympia, PLLC

304 West Bay Dr NW Olympia, WA 98502
General Dermatology, STE 301; Mohs Surgery, STE 204

Welcome to our practice!

Please take the time to fill out the Health History Questionnaire below prior to your visit, as this will help speed the initial aspects of your visit with us.

Patient Name:_____ DOB:_____ Primary MD:_____

Pharmacy:_____

Past Medical History: ***(Please add dates)***

- Anxiety
- Arthritis: Type_____
- Asthma
- Atrial Fibrillation / Irregular heartbeat
- BPH (prostate)
- Bone Marrow Transplant
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- Fibromyalgia
- Gastroesophageal Reflux
- Other_____
  _____
  _____
  _____
- Hearing Loss
- Hepatitis: A B or C
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

Please circle all that apply.

Past Surgeries: ***(Please add dates)***

- Appendix (appendectomy)
- Bladder (Cystectomy)
- Breast: Mastectomy R L B
- Breast: Lumpectomy R L B
- Breast: Biopsy R L B
- C Section
- Colon (colectomy for cancer)
- Colon (colectomy for diverticulitis)
- Gallbladder (cholecystectomy)
- Heart: PTCA
- Heart: Mechanical Valve replacement
- Heart: Biological Valve replacement
- Heart: Transplant
- Uterus: Hysterectomy_____
- Joint replacement: Knee R L B
- Other:_____
  _____
  _____
  _____
  _____
- Joint replacement: Hip
- Kidney biopsy
- Kidney removal (nephrectomy)
- Kidney stone removal
- Kidney transplant: Year_____
- Ovaries: Endometriosis
- Ovaries (Ovarian cancer)
- Prostate removal (cancer)
- Prostate: biopsy
- Prostate (TURP procedure)
- Skin Surgery
  Biopsy
  Basal cell carcinoma
  Squamous cell carcinoma
  Melanoma
  Other:_____
  _
- Spleen (splenectomy)
- Testicles (orchidectomy)
- Tonsillectomy

Dermatology History:

- Acne
- Actinic Keratoses (pre-cancers)
- Asthma
- Basal cell skin cancer**
- Blistering sunburns
- Dry skin
- Eczema
- Other:_____
- Flaking or itchy scalp
- Hay Fever / Allergies
- Melanoma**
- Poison Ivy
- Precancerous or atypical moles
- Psoriasis
- Rosacea
- Squamous cell skin cancer**

** If yes, please list cancer, location, date, and treatment
_____
_____
_____
_____
_____
_____
_____

Staff Initials / Date_____

Please fill out other side →

Patient Name: _____ DOB:_____

Do you wear Sunscreen? No_____ Yes_____ (SPF_____)

Tanning salon? No_____ Yes_____ Past_____

Family history of skin cancer? No_____ Yes_____ Type: BASAL CELL SQUAMOUS CELL MELANOMA UNKNOWN (circle one)

If yes, (circle) mother father sister brother daughter son uncle aunt nephew grandmother grandfather grandson granddaughter Other_____

Please list any medications and supplements or vitamins that you are taking:

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Are you allergic to latex? Yes No Reaction:_____

Please list any allergies to medicines or anesthesia that you may have and the reaction:

1.	3.	5.
2.	4.	6.

Social History:

Do you use illicit, intravenous or recreational drugs? Yes____Type:_____ No_____

Do you drink alcohol? ____ No ____Yes (circle one) Less than 1 drink/day; 1-2 drinks/day; 3 or more drinks/day

Do you feel safe at home? Yes_____ No_____

Marital status? Single____ Married____ Divorced____ Widowed____ Partner____

Occupation (s):_____

Hobbies / Leisure activities:_____

Where did you grow up and/or spend significant time in your life?_____

Do you or have you ever smoked?

Current everyday smoker: _____ packs per day
_____Occasional smoker
_____Former smoker ____ year quit
_____Never smoker

How often do you exercise?

_____ Several times a day
_____ Once a day
_____ A few times a week or month
_____ Never

What is your caffeine use?

_____Several times a day
_____ Once a day
_____ A few times a week or month
_____ Never

(Women) Are you pregnant? ____Yes ____No ____Are you planning? If yes, due date?_____

Staff Initials/Date_____

Dermatology & Allergy Specialists of Olympia
Main Office: 304 West Bay Dr NW, Suite 301, Olympia, WA 98502 Voice:(360) 413-8760 Fax: (360) 413-8839
Allergy Office: 703 Lilly Road NE, Suite 103, Olympia, WA 98506 Voice: (360) 413-8265 Fax: (360) 413-8868

Notice of Privacy Practices Acknowledgement

Due to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we must have your written acknowledgement of having had an opportunity to receive and review a copy of our Notice of Privacy Practices.

I, _____ acknowledge the opportunity to review and receive
(PRINT PATIENT NAME HERE)

Dermatology and Allergy Specialists of Olympia, PLLC. Notice of Privacy Practices.

OFFICE USE ONLY:

☐ Patient refuses, or is unable to acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Employee Signature Date

Disclosures to Family and Friends and Clinical Information Calls

Under normal circumstances we would share some of your private health information (PHI) with some of your family members. Please read and complete both of the following:

1. I agree that this office may disclose my private health information to only the following individuals that are my **family members or friends (PLEASE PRINT)**

NAME: _____ PHONE NUMBER:_____

RELATIONSHIP: _____ ☐ ALL INFORMATION ☐ FOR EMERGENCY ONLY

NAME: _____ PHONE NUMBER:_____

RELATIONSHIP: _____ ☐ ALL INFORMATION ☐ FOR EMERGENCY ONLY

OR:

☐ I do not want my private health information disclosed to any individual asking about me, regardless of whether or not they may be a family member or friend.

2. How would you like us to communicate with you regarding clinical information (such as test results and treatment plans)? Following your visit may we call and leave a message on the following:

☐ Home Phone (___)_____ ☐ Cell phone (___)_____

☐ Work Phone (___)_____ ☐ Other (___)_____

_____ _____
Signature **Date**

_____
Relationship to patient if signed on behalf of the patient

Dermatology & Allergy Specialists of Olympia

Main Office: 304 West Bay Dr. NW, Suite 301, Olympia, WA 98502 Voice:(360) 413-8760 Fax: (360) 413-8839

Financial Policy and Assignment of Benefits

We would like to share our financial policies with you. The following outlines our mutual business responsibilities and allows us to provide quality, timely and complete health care.

PLEASE READ ALL INFORMATION CAREFULLY AND ACKNOWLEDGE BY INITIALING IN THE DESIGNATED AREAS. WHEN COMPLETED SIGNATURE IS NEEDED ON BACK PAGE.

Patient: _____

Birthday: _____ **Account #:** _____

Patient Responsibility, you agree to:

- Bring all your current insurance card(s) and picture ID to each visit. You are responsible to provide us with all current insurance information. Failure to provide us with the most current insurance information will result in all incurred charges being patient/legal guardian responsibility.
- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.
- Payment for any co-pays as well as any charges for non-covered services or any outstanding balances are expected to be paid at the time of your visit. Your co-payment will be collected at the time of service - no exceptions. If there is no copay made at time of visit, a $10 billing surcharge may be added. We accept cash, checks, Visa, and Master Card.
- **Contact the Business Office prior to your visit if you have no insurance to make payment arrangements, we will ask that you pay a small deposit prior to being seen of $100 for new patients and $75 for established patients.**

I have read and understand the billing policy _____ (please initial)

- To cancel your appointment please call at least 2 business days in advance. Our business days are Monday through Friday. **We may charge a "missed appointment" fee for the following:**
  - **$50 for Office Visits**
  - **$100 for Procedures**

***Cancellations made after normal business hours may also be subject to cancellation fee**

I have read and understand the cancellation policy _____ (please initial)

- Notify us of a change of address, telephone numbers, employer or insurance.
- Obtain any necessary referrals or authorizations prior to your visit, if your plan requires this to see a specialist.
- Angry or foul language directed at our staff is not tolerated and will be grounds for immediate dismissal from our practice.

SEE BACK PAGE →

Dermatology & Allergy Specialists Responsibility

- Commercial Insurance Patients: If we participate with your plan, we will bill your insurance for you. If we do not participate with your insurance, as a courtesy we will file your claims. Understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement, unless other arrangements have been made.

- Medicare Insurance patients: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we may bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) may be collected at the time of service, along with charges for non-covered or cosmetic services (you will be asked to sign an Advance Beneficiary Notice form in the event that a service is provided for which we expect Medicare will not pay).

- Collections: We may assess a 1% monthly interest charge on unpaid balance over 60 days old. If we have not received payment in full after 90 days from the date of service, we may refer your account to an outside collection agency where you will be responsible to pay the costs of collection (including court costs and reasonable attorney fees). Any legal action shall be brought and maintained exclusively in a state court of Thurston County, State of Washington and the parties hereby submit themselves to the personal jurisdiction and venue of those courts for the purpose of any such action and hereby waive any defense related to personal jurisdiction, process or venue brought in those courts. If your account is turned over to collections or you have an unpaid balance that is 90 days or older, you may no longer be able to be seen at Dermatology and Allergy Specialists of Olympia, PLLC. A fee of $50 will be charged to any account with a check returned unpaid by the bank.

Remember whether you do or do not have insurance you are financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (360) 413-8408.

I authorize payment to be made directly to Dermatology and Allergy Specialists of Olympia. I understand any monies paid over and above my indebtedness will be refunded. I understand that whether I sign as patient or responsible party (e.g. parent, legal representative, guarantor), I am directly responsible and will pay for services rendered and not paid by my insurer, and that assignment of benefits under any insurance policy or medical reimbursement plan shall not be deemed a waiver of Dermatology and Allergy Specialists of Olympia's right to require payment directly from me. I understand and agree to adhere to Dermatology and Allergy Specialists of Olympia's financial/credit policy.

I have read and have a full understanding of the financial policy of Dermatology and Allergy Specialists of Olympia, PLLC and agree to these terms therein.

Signature: _____ Date: _____

_____ Relationship to Patient: _____

Print clearly signer's name